Communicable Disease UPDATE

Newsletter of the Bureau of Communicable Disease Control, Massachusetts Department of Public Health Vol. 6, No. 4 Fall 1998

Meningococcal vaccine not recommended for routine college immunization

In September 1997, the American College Health Association issued a recommendation that colleges consider immunizing students against meningococcal disease. At this time, the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC) do not recommend routine administration of meningococcal vaccine to college students. They recommend that vaccine be provided for a defined target population of students **only if** a school-based outbreak of meningococcal disease is identified.

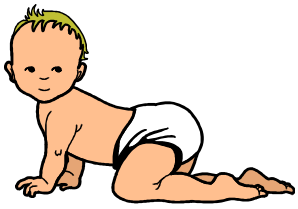
The Massachusetts Department of Public Health (MDPH) follows the guidelines and recommendations of the ACIP and CDC, and the MDPH **is not recommending routine immunization of college students against meningococcal disease.** We will not be providing meningococcal vaccine for school-based pre-exposure vaccination programs.

The CDC has concluded that routine vaccination of college students for meningococcal disease is not a cost-effective method of preventing disease in this population. This conclusion reflects the limitations of the vaccine. The vaccine is effective against only four of nine serogroups of the bacterium known to cause invasive disease. The vaccine confers short-term immunity (1 to 4 years) and has an efficacy rate of about 90% in persons over five years of age. Finally, the vaccine does not eradicate nasopharyngeal carriage of the organism.

Chemoprophylaxis of close contacts of a case of invasive meningococcal disease is the recommended method for control and prevention of disease in non-outbreak situations. Close contacts of the case include household contacts as well as individuals who have exchanged saliva or respiratory secretions with the case. Primary prevention lies in education about basic hygiene, including not sharing foods, beverages, or cigarettes.

Over the next two years, the CDC and state health departments will conduct a special surveillance project to determine if US college students have a greater risk for acquiring invasive meningococcal disease. If subgroups of the student population are found to be at increased risk, then changes in the ACIP recommendations concerning routine vaccination with meningococcal vaccines may be considered.

New rotavirus vaccine



Rotaviruses are the leading cause of viral gastroenteritis in infants throughout the world. Annually in the United States, they are estimated to cause some 3 million cases of diarrheal illness, 500,000 physician visits, 50,000 hospitalizations, and 20-40 deaths. Almost all children are infected in the first two or three years of life. In the United States, infection is seasonal, peaking in the southwest in November, spreading north and east, and peaking in New England in April-May.

A vaccine to protect against rotavirus disease, Rotashield®, manufactured by Wyeth-Lederle, was licensed on August 31, 1998. It is an oral, tetravalent vaccine (i.e., it includes antigens of four serotypes) and consists of live attenuated, non-disease causing viruses. The vaccine is 70-95% effective in preventing severe rotavirus diarrhea.

Recommendations regarding the use of rotavirus vaccine are expected to be issued by the Advisory Committee on Immunization Practices (ACIP) in the next few months. The recommended schedule is three doses, at 2, 4, and 6 months of age, to be given simultaneously with other vaccines. The first dose should not be given after six months of age, with subsequent doses not given after the first birthday.

The Massachusetts Immunization Program anticipates distribution of rotavirus vaccine in the next few months, pending publication of the ACIP recommendations and establishment of a federal contract for vaccine purchase.

Inside

Epidemiology

Lyme disease activities

The Massachusetts Department of Public Health (MDPH) has been conducting passive Lyme disease surveillance in the Commonwealth since 1985. This system involves a combination of physician reports to local boards of health and laboratory reports to MDPH, which follows up with health care providers. This passive surveillance system underestimates the actual number of cases of Lyme disease. Active surveillance in areas of high, moderate, and low endemicity is needed to better understand the occurrence of Lyme disease in Massachusetts.

Therefore, the MDPH has begun implementing a new Massachusetts Lyme Disease Surveillance System. The goal is to establish active surveillance of Lyme disease cases in eight areas. The eight areas include Ipswich, Framingham, the Quabbin Reservoir (Belchertown/Ware), Bourne, Rochester, Yarmouth, Martha's Vineyard, and Nantucket. Establishing this active, sentinel surveillance system involves recruiting, enrolling, and following up with local health departments, hospitals, and providers within the selected sentinel sites. Efforts to fully implement this system for the start of the 1999 Lyme disease season are on target.

In addition to conducting active surveillance in the eight targeted areas, the MDPH is also taking measures to improve reporting of Lyme disease cases elsewhere in the state. To accomplish this, we have designed a simplified case reporting form which allows physicians to list multiple cases of Lyme disease on a single report form. To facilitate reporting, the Lyme disease case report form can be sent directly to MDPH. We will then inform the local health department. If a case is initially reported to the local health department, they should use the new reporting form as well. You may request a copy of the new Lyme disease case report form by calling (617) 983-6800.

With Lyme disease vaccine soon to be available, the Advisory Committee on Immunization Practices is currently drafting recommendations for use. There are two vaccines currently awaiting approval; one is manufactured by SmithKline Beecham, and one by Pasteur Merieux Connaught. Both vaccines consist of recombinant *Borrelia burgdorferi* outer surface lipoprotein A (OspA). Immunization would require a series of three doses administered over the course of one year, as well as periodic boosters. Efficacy trials have been completed in two population study groups, aged 15 to 65 years and 19 to 92 years. In Lyme disease endemic areas, the SmithKline Beecham vaccine proved 76% effective at preventing Lyme infections after the third dose, and the Pasteur Merieux Connaught vaccine proved 92% effective at preventing Lyme infections after the third dose (New England Journal of Medicine; July 28, 1998). It is unknown at this time when the vaccines will be licensed.

Hepatitis C: the hidden epidemic

Almost 4 million Americans are believed to be infected with the hepatitis C virus (HCV). Due to aggressive blood, organ, and tissue donor screening, among other efforts, the incidence of acute cases of HCV is decreasing. However, the number of people developing chronic liver disease from past infection with HCV is rising. An estimated 8,000-10,000 deaths occur each year from HCV-associated chronic liver disease. No vaccine is available to prevent hepatitis C. Because of limited data, recommendations for prevention, treatment, and control are also limited.

To respond to this increasing public health problem, the Massachusetts Department of Public Health, Division of Epidemiology and Immunization, is expanding its efforts to raise public awareness of hepatitis C and to offer professional education, including dissemination of materials on identification, reporting, and counseling. Specific expanded activities will include developing guidelines for local health departments, as well as working with them to implement these guidelines. Surveillance systems will be expanded to improve reporting and completeness of reporting. More complete reporting can improve the ability of the Department to identify individuals and groups at risk for hepatitis C and assess the burden of infection. The ultimate goal of improved surveillance is to create focused and effective educational programs directed toward treatment, control, and prevention.

Holiday food safety handout

On page 4 you will find a ready-to-copy handout with holiday food safety tips. Feel free to copy it and distribute it in your town, within your agency or institution, or anywhere you think it might be helpful. Please let us know if this kind of insert is helpful to you.

STD: changing directions

In 1996, the Institute of Medicine (IOM) issued a landmark report about sexually transmitted diseases (STD) in America. Entitled "The Hidden Epidemic," the report provides stark details about the United States having the highest rates of STD among all of the industrialized nations, and the human and economic toll that these diseases exact. "The Hidden Epidemic" proceeds to point out that the United States has no systematic plan to deal with this health crisis, and then proposes such a plan.

There are four major strategies recommended by the IOM: 1) promotion of healthy sexual behavior; 2) development of leadership; 3) focus on adolescents and underserved populations; and 4) ensured access to services. There are numerous tactics suggested for each strategy. The result is a coherent plan for bringing this hidden epidemic to light and combating its impact.

The Centers for Disease Control and Prevention (CDC) has adopted the IOM plan and instituted it as the basis for funding programs. The Comprehensive STD Prevention Systems (CSPS) program grant announcement requires public health STD prevention programs to re-design their activities in line with the strategies and tactics suggested by the IOM. Thus, while retaining the historical core functions of clinical services, laboratory testing, surveillance, case investigation, and education, the Massachusetts Division of STD Prevention will strive to solicit community input and strengthen community partnerships. It will also reach out to higher-risk groups by forming or increasing partnerships with providers of HIV prevention, family planning, correctional care, adolescent health, and others.

The next few years will be an exciting and dynamic time. We expect to try new ways to promote healthy sexual behaviors on the individual, group, and community levels. This will involve experimenting with additional educational media in the clinics, using behavior change theory in designing counseling practices, and working with communities and service providers to try to change behavioral norms. We expect to work more intensively than in the past with professional, community, political, and religious leaders to enlist their cooperation into STD prevention activities. We will be reviewing all activities to ensure that services are always available to members of historically underserved groups. These include (but are not limited to) teens, the homeless, the poor, incarcerated populations, minorities, and women.

Finally, we will work to extend dedicated clinical services, try to ensure that STD screening and treatment guidelines are adopted by private sector providers, and ensure that providers of related services (e.g., HIV counseling, substance abuse treatment, etc.) are aware of and supportive of the need for referrals. We will continue to provide educational opportunities to clinicians and laboratorians, yet add more courses and conferences aimed at non-clinician partners and the public.

STD trends

Overall. Incidence rates of STDs continue a seven year downward trend, with some exceptions. Gonorrhea in 1997 (2,077 cases) is at the lowest number of reported cases since 1959. Chlamydia became a reportable disease in Massachusetts in late 1985. Reported cases in 1997 (7,330) are 28% below the 1989 peak level (10,131) of reported cases; however, the number of cases is 8% higher than in 1996 (6,791). Much of this increase is the result of increased chlamydia screening through the department's efforts working with Family Planning Clinics.

Syphilis. Overall rates of syphilis declined 64%, from 28 cases per 100,000 population in 1990, to 11 cases per 100,000 population in 1997. This is a small increase from the 1996 rate of 10 cases per 100,000 population. Of greater significance is the decline of lesion syphilis (primary and secondary), down 90% from 11.6 cases in 1990 to 1.2 cases per 100,000 population in 1997. The current rate is 76% below the *HEALTHY PEOPLE 2000* objective of 5 cases per 100,000.

Gonorrhea. Gonorrhea rates declined 71% from 125 in 1990 to 35 cases per 100,000 population in 1997. This is 65% below the *HEALTHY PEOPLE 2000* objective of 100 cases per 100,000.

Chlamydia. Chlamydia rates declined 45%, from 204 in 1990 to 122 cases per 100,000 population in 1997, which falls 13% below the *HEALTHY PEOPLE 2000* objective of 140 cases per 100,000.

In Massachusetts, the risk of acquiring a sexually transmitted infection is not equally distributed across all sexually active populations. Risk varies dramatically between individuals and groups depending on age, background, and socioeconomic status. The large number of at-risk individuals in socio-economically deprived communities, particularly adolescents, indicates that more needs to be done.

Holiday Food Safety Tips

Every year, over 30 million people in the United States will get sick from a foodborne illness--what most people call "food poisoning." This holiday season, help keep yourself and your family safe from foodborne illness by following these easy steps.

1. Wash your hands!

This might sound obvious, but the truth is that anyone can carry germs (bacteria and viruses) on their hands. If you prepare food without washing your hands, some of those germs can get into the food and make people sick! Use plenty of soap and water to wash before you start cooking and after you handle any raw meat, poultry, or eggs. Don't forget that it's also important to wash your fruits and vegetables before eating them.

2. Be careful with that cutting board!

Just like your hands, cutting boards and knives need to be thoroughly washed after touching any raw meat or poultry. Germs from raw foods like chicken can contaminate vegetables or other foods cut on the board after raw meat. Never use the same plate for both raw and cooked food. Plates, knives, forks, and utensils that touch raw meat or poultry need to be washed before being used with other foods.

3. Cook your seafood and meats!

Even if you're in a rush to serve your holiday dinner, don't be fooled into thinking a big turkey or roast is completely cooked without using a meat thermometer. All ground beef, including hamburgers, should be cooked to 160°F, and all poultry—whole birds with or without stuffing—should be cooked to 180°F. Juices that come out of meat should be clear. Remember to completely cook all seafood, like fish or clams. Keep in mind that a microwave can heat foods unevenly, so check all parts of the food to make sure they are cooked.

4. Keep hot foods hot and cold foods cold!

Always serve hot foods while they are hot. If you have leftovers, place them in small containers so they can cool off quickly, and put all leftovers into the refrigerator right away. Take the stuffing out of a turkey or roast first, and then cut the meat into pieces before refrigerating. Keep cold foods in the refrigerator until just before you are ready to use them.

For more information and free brochures:

Massachusetts Department of Public Health (MDPH)
Division of Food and Drugs: (617) 983-6712
Division of Epidemiology and Immunization: (617) 983-6800

United States Department of Agriculture (USDA) Meat and Poultry Hotline: 1-800-535-4555

FDA's Food Information and Seafood Hotline: 1-800-332-4010

You be the epi

New hepatitis B vaccine formulation & distribution plan

As of August 27, 1998, the Merck Vaccine Division replaced their 2.5 mcg pediatric dose of hepatitis B vaccine with a 5.0 mcg pediatric/adolescent dose. The Massachusetts Immunization Program will distribute both the Recombivax HB® and Engerix-B® vaccine formulations, but the two types will be allocated by immunization region (outlined below). Have questions? Please call either Bob Morrison, Vaccine Manager, or Linda Keller, Hepatitis B Coordinator at (617) 983-6800.

Recommended Doses/Regions of Distribution for Currently Licensed Hepatitis B Vaccines*

RECOMBIVAX HB® (Merck & Co.)

Immunization Regions:	Central, Southeast
Pediatric/Adolescent Formulation: (infant through 19 years)	5.0 mcg/0.5ml
Adult Formulation: (≥ 20 years)	10 mcg/1.0 ml

ENGERIX-B® (SmithKline Beecham)

Immunization Regions:	Western, Metropolitan Boston, Northeast
Pediatric/ Adolescent Formulation: (infant through 19 years)	10 mcg/0.5ml
Adult Formulation: (≥ 20 years)	20 mcg/1.0ml

*Always Remember to Check the Package Insert!

Three weeks after a 37-year-old man returned from a trip to Asia, he presented to his physician's office with a history of low-grade fever, sore throat, general body aches, and other flu-like symptoms. Upon questioning, the man stated that he had experienced a penile discharge which had resolved by the time of the office visit, and that he had sexual relations while on his trip. Because of the history of the discharge, the physician suspected gonorrhea. He treated the man with ciprofloxacin and sent him home. The man returned one week later with continued sore throat and other non-specific symptoms. What should be the next steps?

Because of the continuing sore throat, the doctor asked more specific questions about the man's activities during travel. After further questioning, the patient stated that he'd had oral sex while on his trip. The doctor did a throat and a urethal culture, because quinolone-resistant gonorrhea is known to exist in Asia. The doctor also re-treated, but this time with ceftriaxone. Indeed, cultures grew *Neisseria gonorrhoeae*, but it was resistant to the quinolones (ciprofloxacin, norfloxacin, and ofloxacin). It was susceptible to penicillin and ceftriaxone. Symptoms resolved without incident, and there were no secondary cases among the patient's contacts since returning.

This incident is based upon a recent case that was investigated by the Division of STD Prevention. It demonstrates the need for specific history-taking, as well as the importance of laboratory cultures. New non-culture diagnostic technologies are fast, relatively easy, and extremely sensitive; however, they do not allow for antibiotic susceptibility testing.

Communicable Disease Updates
January – June 1997 vs. January – June 1998: Reported Cases

DISEASE	1997	1998*	% change from 1997
AIDS	458	505	+10%
Botulism	0	0	–
Campylobacter	726	570	-21%
Chlamydia	3,546	4,107	+16%
Cryptosporidiosis	24	37	+54%
E. coli O157:H7	30	61	+103%
Giardiasis	394	348	-12%
Gonorrhea	1,095	980	-11%
Invasive HI** (<5 yrs.)	3	7	+133%
Hepatitis A	155	47	-70%
Hepatitis B (acute)	37	32	-14%
Lyme Disease	94	242	+157%

*Preliminary data. Reporting not yet complete.
**HI = Haemophilus Influenzae

DISEASE	1997	1998*	% change from 1997
Measles	8	2	-75%
Mumps	2	1	-50%
Invasive Meningococcal Disease (Neisseria)	60	28	-53%
Pertussis	289	325	+12%
Rabies (animal)	114	217	+90%
Rubella	1	8	+700%
CRS***	0	0	–
Salmonellosis	523	541	+3%
S. typhi (Typhoid)	11	9	-18%
Shigellosis	108	129	+19%
Syphilis (early)	102	78	-24%
TB	117	119	+2%

***Congenital Rubella Syndrome

Immunization

New school regulations

The regulations governing the Immunization of Students Before Admission to School (105 CMR 220.00) have been amended to reflect the most recent recommendations of the American Academy of Pediatrics (AAP) and the Advisory Committee on Immunization Practices (ACIP).

Individuals and institutions affected by these new amendments include students attending certain preschools and all elementary schools, high schools, and institutions of higher education in the Commonwealth.

The new regulations clarify and expand several definitions and specify the student groups and institutions to which they apply (see Table 1).

In addition to the new and expanded definitions, there are new antigen-specific requirements for preschool, schools, and college entry. The regulations also standardize the age for the "catch-up" vaccination of adolescents at 7th grade entry. These requirements will be phased-in over a six year period to incorporate all grades and college years, as outlined in Table 2.

These requirements will help to optimally protect the children of Massachusetts against vaccine preventable diseases. Please review the Massachusetts Department of Public Health's 1998 *Immunization Guidelines* for further details regarding the immunization schedule and requirements for school entry or call the Massachusetts Immunization Program at (617) 983-6800.

Table 1 – New Definitions

Definition	Effective 9/1/1998	Effective 1/1/1999
Student	• All students attending certain preschools, schools, and post-secondary institutions; • Public or private setting; • Full or part-time foreign students on a student or other visa	---
Certificate of Immunization	• Form or letter signed by provider or designee; • Report from MIIS	---
Post-secondary Institution	---	• Any college, university, institute or school accredited by the New England Association of Schools and Colleges

Table 2 – New Requirements for School Entry

Required at Entry to…	New Requirements		Existing Requirements to Remain in Effect
	Effective 9/1/99	Effective 9/1/00	
Preschool	• 1 dose varicella[1]	---	• ≥ 4 doses DTaP/DTP • ≥ 3 doses polio[2] • 1 dose MMR • ≥ 3 doses Hib • 3 doses hepatitis B[3]
Kindergarten	• 1 dose varicella[1] • 4 doses polio[2] (if a mixed IPV/OPV schedule is used)	---	• 5 doses DTaP/DTP • 2 doses MMR[5] • 3 doses hepatitis B[3]
Grades 1-6	---	---	• ≥ 4 doses DTaP/DTP • ≥ 3 doses polio[2] • 2 doses MMR[5] (K-3) • 3 doses hepatitis B[3] (K-2)
Seventh Grade	• 3 doses hepatitis B[3] • 1 or 2 doses varicella[1] • 1 Td booster (if ≥ 5 years since the last dose)	---	• ≥ 4 doses DTaP/DTP • ≥ 3 doses polio[2] • 2 doses MMR[5]
College	---	• 3 doses hepatitis B[4]	• 1 Td booster within last 10 years • 2 doses MMR[5]

[1]Effective 8/1/98, 1 dose is required for attendance at centers licensed by the Office of Child Care Services for all children born on or after 1/1/97 and who are > 19 months of age, and who are without a physician-certified reliable history of chickenpox disease, which consists of 1) physician interpretation of parent/guardian description of chickenpox; 2) physician diagnosis of chickenpox; or 3) serologic proof of immunity.

[2]4 doses are required, unless the third dose of an all OPV or all IPV series is given after the 4th birthday, in which case only 3 doses are required.

[3]Serologic proof of immunity is acceptable.

[4]Required for all full and part-time health science students. This will be phased-in incrementally and after 2005, will apply to freshmen – graduate students.

[5]2 doses measles, 1 dose mumps, 1 dose rubella

TB community prevention project

The Division of TB Prevention and Control is strengthening secondary prevention efforts (early intervention measures to detect and treat TB infection) to better reach populations infected with TB. Historically, the TB Division has focused mainly on tertiary prevention (intervention measures to detect and treat TB disease), assuring completion of therapy for persons with active disease, in order to achieve primary prevention of reducing transmission of infection. However, at this time, 95% of the TB cases in Massachusetts complete an appropriate treatment regime.

The goal of the TB Community Prevention Project is to decrease the pool of people at risk from progressing to TB disease by identifying infected people, ensuring access to services, and providing appropriate follow-up care. Two teams were created to work with local community leaders, public health professionals, and private providers to create a shared commitment. Team members were drawn from all areas of the TB Division. Members of the Refugee and Immigrant Health Program volunteered to participate. Team 1, led by Nancy Taylor Flynn, will coordinate efforts with communities in the Northeastern and Western regions of Massachusetts. Team 2, led by Jo-Ann Keegan, will coordinate efforts with the high-risk communities in the Metro-Boston and Southeastern regions. Jennifer Alexander, a Public Health Prevention Specialist from the Centers for Disease Control and Prevention, will play an integral part in the design, implementation, management, and evaluation of the project. Community service coordinators Carmen Gorman and Judy Martinez will help facilitate the community intervention strategies.

Phase 1: The teams have begun community assessments to identify populations at risk for TB. The goal is to assist these communities in delivering services to populations at risk, such as newcomers.

Phase 2: Teams plan TB prevention strategies, educate the community, and build community consensus to support the prevention project.

Phase 3: In subsequent years, the teams will expand to include new communities until all high-risk populations in Massachusetts have access to effective preventive TB services. Evaluation and monitoring of the community prevention strategies will be ongoing.

Southeast regional clinical services highlight

Tuberculosis Surveillance Area (TSA 5)
TSA Nurse: Christine Jackson, RN

The Division of TB Prevention and Control funds 26 TB clinics throughout the state; these clinics provide TB services free of charge, and they are critical to TB prevention and control efforts in Massachusetts. TB clinic physicians and nurses are specialists in TB prevention and control. Interpreters and outreach workers ensure patients receive culturally and linguistically appropriate services. The Refugee and Immigrant Health Program provides outreach educators to assist the refugee and immigrant populations. We will highlight one of these clinics in each region in upcoming newsletters.

St. Luke's Hospital, New Bedford, MA

The New Bedford TB Clinic is one of seven TB clinics located in high-risk communities in the Southeastern region of Massachusetts (TSA 5). The TB Clinic is located at St. Luke's Hospital, which is the New Bedford member of the Southcoast Hospitals Group. The clinic is open on Tuesday afternoons, and generally 12–15 patients are seen per clinic. Dr. Daniel Martin is the new TB clinic physician. He replaces Dr. Channin, who retired after many years of dedicated and distinguished service. The New Bedford Health Department nurses, Mrs. Dorothy Richard, RN, and Mrs. Pat Cyr, RN, and clerical personnel staff the clinic. Mrs. Judy Hart is the supervisor, and Mrs. Fran Fuller is the clinic manager. Appointments are made through the New Bedford Health Department (508) 991-6284.

In 1997, there were 12 cases of tuberculosis in the greater New Bedford area, as compared to 5 cases in 1996. This increase was due in part to a cluster of cases. The diligent expertise of the clinic staff helped to identify the population at-risk through thorough contact investigation. Contact investigation is an essential means of identifying people who have TB infection or disease. Contacts were evaluated and treated at the TB clinic. After a year and a half, spread of TB appears to have ended.

CD UPDATE
Bureau of Communicable Disease Control
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Save the dates

CDC Live Satellite Training Courses:

Preparing for the Next Influenza Pandemic
February 25, 1999, two broadcasts at 9–11:30 AM and 1–3:30 PM

This live, interactive satellite broadcast will introduce guidelines to prepare for the next influenza pandemic and facilitate state and local emergency response preparations. The objectives for this course are to: 1) identify the rationale for influenza pandemic preparedness, 2) identify the guidelines for influenza pandemic preparedness, and 3) initiate influenza pandemic preparedness planning.

The target audience is state and local health officers; federal, state and local emergency preparedness planners; immunization program managers; physician and health care organizations; laboratory managers; pharmacists; hospital infection control practitioners; members of the media; and funeral director associations. This course is free and will be held at the State Laboratory Institute in Jamaica Plain. CEUs will be offered. For more information or registration, call Vicki Soler, RN, Division of Epidemiology and Immunization at (617) 983-6800.

Epidemiology and Prevention of Vaccine Preventable Diseases
March 25, April 1, 8 and 15, 1999 (four–part series)

This course will be held at the State Laboratory Institute in Jamaica Plain. CEUs will be offered. For registration, call Victoria Soler, RN, Division of Epidemiology and Immunization at (617) 983-6800. More information about the course will be announced in the next issue of this newsletter.

TB Today:

Watch for the announcement of the TB Today course planned for April 12–15, 1999. For more information call Denise Lancto at (617) 983-6970.

Foreign-language VIS available

Current Vaccine Information Statements (VIS) in 17 languages are available from the Massachusetts Immunization Program (MIP). A complete list will be published in the next issue of this newsletter. To obtain copies, contact your local regional immunization office or call the MIP at (617) 983-6800.

Address Changes?? Address deletions??

Please call Jacki Hanson at (617) 983-6559 if you want to be removed from our mailing list; are receiving duplicate copies; or have any name/address corrections.

A Notice To Our Readers. This newsletter is also available on our web page. The address is: [http://www.magnet.state.ma.us/dph/]. Click on "Publications/Statistics" and scroll down to *Communicable Disease Update*. The newsletters are in PDF format. You will need adobe acrobat software, available free at [http://www.adobe.com], to view and download information.

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